

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0027532</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Manorcare at Normal</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/00</u> to <u>05/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>510 Broadway</u> <u>Normal</u> <u>61761</u> <div style="display: flex; justify-content: space-between;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>McLean</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u> (Title) <u>Vice-President- Reimbursement</u>																									
Telephone Number: <u>(309) 452-4406</u> Fax # <u>(309) 454-7908</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																									
IDPA ID Number: <u>520886946006</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>11/01/81</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Craig Dekany</u> Telephone Number: <u>(419) 252-5740</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Normal# 0027532 Report Period Beginning: 06/01/00 Ending: 05/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>416</u>	<u>3,317</u>	<u>3,866</u>	<u>7,599</u>	8
9	SNF/PED					9
10	ICF	<u>12,162</u>	<u>12,696</u>	<u>166</u>	<u>25,024</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,578</u>	<u>16,013</u>	<u>4,032</u>	<u>32,623</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.28%

D. How many bed-hold days during this year were paid by Public Aid?

157 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/81 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 26 and days of care provided 3,337Medicare Intermediary B/C Maryland

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/01 Fiscal Year: 5/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/00 Ending: 05/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	158,510	8,182	9,529	176,221	1,135	177,356		177,356		1
2	Food Purchase		151,214		151,214		151,214	(152)	151,062		2
3	Housekeeping	71,033	9,494	6,712	87,239		87,239		87,239		3
4	Laundry	18,681	3,978	19,387	42,046		42,046	(10,770)	31,276		4
5	Heat and Other Utilities			82,448	82,448	5,204	87,652		87,652		5
6	Maintenance	33,137	4,009	28,348	65,494		65,494		65,494		6
7	Other (specify):* Med Waste Util.			420	420		420		420		7
8	TOTAL General Services	281,361	176,877	146,844	605,082	6,339	611,421	(10,922)	600,499		8
	B. Health Care and Programs										
9	Medical Director			14,975	14,975		14,975		14,975		9
10	Nursing and Medical Records	1,188,095	89,287	246,904	1,524,286	20,569	1,544,855		1,544,855		10
10a	Therapy	123,479	2,273	9,063	134,815		134,815		134,815		10a
11	Activities	63,521	2,801	3,383	69,705		69,705		69,705		11
12	Social Services	25,607	63	70	25,740		25,740		25,740		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,400,702	94,424	274,395	1,769,521	20,569	1,790,090		1,790,090		16
	C. General Administration										
17	Administrative	92,139		280,132	372,271	(96,878)	275,393		275,393		17
18	Directors Fees										18
19	Professional Services			4,195	4,195		4,195	(4,195)			19
20	Dues, Fees, Subscriptions & Promotions			56,295	56,295		56,295	(22,307)	33,988		20
21	Clerical & General Office Expenses	133,133	37,841	(45,475)	125,499		125,499	66,995	192,494		21
22	Employee Benefits & Payroll Taxes			409,460	409,460	(10,885)	398,575		398,575		22
23	Inservice Training & Education			965	965		965		965		23
24	Travel and Seminar			9,064	9,064		9,064		9,064		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			19,794	19,794		19,794		19,794		26
27	Other (specify):*										27
28	TOTAL General Administration	225,272	37,841	734,430	997,543	(107,763)	889,780	40,493	930,273		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,907,335	309,142	1,155,669	3,372,146	(80,855)	3,291,291	29,571	3,320,862		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Normal

#0027532

Report Period Beginning:

06/01/00

Ending:

05/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			236,072	236,072	28,163	264,235		264,235			30
31	Amortization of Pre-Op. & Org.			18,525	18,525		18,525		18,525			31
32	Interest					52,692	52,692	(3,398)	49,294			32
33	Real Estate Taxes			37,569	37,569		37,569		37,569			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,030	24,030		24,030		24,030			35
36	Other (specify):*											36
37	TOTAL Ownership			316,196	316,196	80,855	397,051	(3,398)	393,653			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,962	18,116	77,078		77,078		77,078			39
40	Barber and Beauty Shops			12,491	12,491		12,491		12,491			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*		13,453		13,453		13,453		13,453			43
44	TOTAL Special Cost Centers		72,415	84,810	157,225		157,225		157,225			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,907,335	381,557	1,556,675	3,845,567		3,845,567	26,173	3,871,740			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/00

Ending:

05/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(152)	2		4
5	Telephone, TV & Radio in Resident Rooms	(392)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(10,770)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,398)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,325)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,006)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	4,753	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,195)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	67,965	21		24
25	Fund Raising, Advertising and Promotional	(22,307)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 26,173		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 26,173		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare at Normal

ID# 0027532

Report Period Beginning: 06/01/00

Ending: 05/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Normal# 0027532

Report Period Beginning:

06/01/00

Ending:

05/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(152)	0	0	0	0	0	0	0	0	0	0	(152)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(10,770)	0	0	0	0	0	0	0	0	0	0	(10,770)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,922)	0	0	0	0	0	0	0	0	0	0	(10,922)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,195)	0	0	0	0	0	0	0	0	0	0	(4,195)	19
20	Fees, Subscriptions & Promotions	(22,307)	0	0	0	0	0	0	0	0	0	0	(22,307)	20
21	Clerical & General Office Expenses	66,995	0	0	0	0	0	0	0	0	0	0	66,995	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	40,493	0	0	0	0	0	0	0	0	0	0	40,493	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	29,571	0	0	0	0	0	0	0	0	0	0	29,571	29

Summary B

Facility Name & ID Number	Manorcare at Normal	#	0027532	Report Period Beginning:	06/01/00	Ending:	05/31/01
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Manorcare at Normal# 0027532

Report Period Beginning:

06/01/00

Ending:

05/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	See	Home Office Allocation	\$ 280,132	HCR Manor Care, Inc.	100.00%	\$ 280,132	\$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	9,000	Heartland Management Services	100.00%	9,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 289,132			\$ 289,132	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Normal# 0027532

Report Period Beginning:

06/01/00Ending: 05/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR ManorCare, Inc.Street Address 333 North SummitCity / State / Zip Code Toledo, OH 43604Phone Number (419)252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>1</u>	<u>Dietary - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac</u>	<u>\$</u>	<u>\$</u>	<u>0</u>	1
2	<u>1</u>	<u>Dietary - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac</u>	<u>671,002</u>	<u>407,536</u>	<u>3,496,161</u>	2
3	<u>5</u>	<u>Utilities - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac</u>	<u>262,823</u>		<u>3,496,161</u>	3
4	<u>5</u>	<u>Utilities - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac</u>	<u>2,777,349</u>		<u>3,496,161</u>	4
5	<u>10</u>	<u>Nursing - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac</u>	<u>6,096,791</u>	<u>4,282,378</u>	<u>3,496,161</u>	5
6	<u>10</u>	<u>Nursing - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac</u>	<u>5,221,432</u>	<u>3,383,186</u>	<u>3,496,161</u>	6
7	<u>17</u>	<u>General & Admin - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac</u>	<u>23,025,730</u>	<u>19,694,773</u>	<u>3,496,161</u>	7
8	<u>17</u>	<u>General & Admin - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac</u>	<u>82,128,599</u>	<u>31,955,235</u>	<u>3,496,161</u>	8
9	<u>22</u>	<u>Employee Benefits - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac</u>	<u>2,724,065</u>		<u>3,496,161</u>	9
10	<u>22</u>	<u>Employee Benefits - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac</u>	<u>(9,534,453)</u>		<u>3,496,161</u>	10
11	<u>30</u>	<u>Depreciation - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac</u>	<u>74,480</u>		<u>3,496,161</u>	11
12	<u>30</u>	<u>Depreciation - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac</u>	<u>16,563,680</u>		<u>3,496,161</u>	12
13									13
14	<u>32</u>	<u>Interest</u>		<u>0</u>		<u>14,161,817</u>		<u>52,692</u>	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 144,173,315	\$ 59,723,108	\$ 280,132	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Conv. Sub. Debentures		X	Facility			\$ 684,665	\$ 684,665			\$ 52,692	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8								Interest Income			(3,398)	8	
9	TOTAL Facility Related						\$ 684,665	\$ 684,665			\$ 49,294	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 684,665	\$ 684,665			\$ 49,294	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Manorcare at Normal**# **0027532** Report Period Beginning: **06/01/00** Ending: **05/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	36,282	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	36,282	2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	37,569	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	37,569	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996 34,190 8			
		1997 35,433 9			
		1998 36,800 10			
		1999 36,282 11			
		2000 37,569 12			
			FOR OHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Manorcare at Normal COUNTY McLean
FACILITY IDPH LICENSE NUMBER 0027532
CONTACT PERSON REGARDING THIS REPORT Craig Dekany
TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 20,586

B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1971	\$ 58,339	1
2			1993	42,954	2
3	TOTALS			\$ 101,293	3

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning:

06/01/00

Ending:

05/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1971	1962	\$ 506,817	\$ 54,868		\$ 54,868	\$	\$ 580,365	4
5	9			1994	497,564						5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					112,780		112,780		898,461	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18				1988	207,264						18
19				1989	134,621						19
20				1990	46,332						20
21				1991	15,386						21
22				1992	57,357						22
23				1993	44,829						23
24				1994	137,130						24
25				1995	72,481						25
26	RENOVATIONS-PATIENT ROOMS			1996	22,684						26
27	CARPET/TILE & INSTALLATION			1996	4,392						27
28	CAPITALIZED LABOR			1996	7,272						28
29	WALL/VINYL/DRYWALL			1996	5,194						29
30	SIGNS/BOARDS			1996	1,730						30
31	INSTALL GRID/PANELS			1996	4,402						31
32	CONCRETE WALK/RAMP			1996	2,850						32
33	CABINETS			1996	1,087						33
34	CARPETING			1996	9,845						34
35	ROOFING			1996	24,474						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	ELECTRICAL/LIGHTING	1996	\$ 2,159	\$		\$	\$	\$		37
38	WALLCOVERINGS	1996	5,910							38
39	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433							39
40	INSTALL SHOWER TILE	1996	2,656							40
41	REPAIR COMPRESSOR	1996	900							41
42	CONCRETE WALK	1996	1,053							42
43	PAINTING & DECORATING	1997	15,688							43
44	ROOF REPLACEMENT	1997	3,345							44
45	WALLCOVERINGS	1997	1,788							45
46	TILE & INSTALLATION	1997	2,686							46
47	RETIREMENTS	1987	(29,830)							47
48	RETIREMENTS	1992	(3,110)							48
49	CARPET	1997	1,547							49
50	INSTALL COMPRESSOR	1997	2,583							50
51	ROOF WORK	1997	51,370							51
52	WALK-IN COOLER/FREEZER	1997	9,466							52
53	ALLOC. FAC. PLAN	1997	2,758							53
54	PLUMBING/BATHROOM WORK	1997	1,226							54
55	ELECTRICAL	1997	2,416							55
56	FINISH/STUD	1998	4,865							56
57	PAINTING/WALLCOVERINGS	1998	8,175							57
58	CARPETING	1998	6,460							58
59	PLUMBING	1998	1,456							59
60	ROOFING	1998	2,170							60
61	DOORS/WINDOWS/CASEWORK	1998	9,884							61
62	ELECTRICAL	1998	5,360							62
63	FLOORING/CEILING/COVE BASE	1998	13,283							63
64	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298							64
65	CORPORATE OVERHEAD-PATIENT ROOMS	1998	1,702							65
66	FURNISH & INSTALL STEEL DOORS	1998	2,439							66
67	MILLWORK	1998	1,166							67
68	INSTALL DUCTS	1998	327							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,493,213	\$ 167,648		\$ 167,648	\$	\$ 1,478,826		70

**Improvement type must be detailed in order for the cost report to be considered complete.

05/31/01

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,712,250	\$ 167,648		\$ 167,648		\$ 1,478,826	1
2	INTEREST ON CONSTRUCTION-ARCADIA ADDITION	2000	5,447						2
3	OVERHEAD COST-ARCADIA ADDITION	2000	43,193						3
4	WATER HEATER	2001	9,350						4
5	8 REPLACEMENT WINDOWS	2001	5,812						5
6	MIXING VALVE	2001	3,397						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,779,449	\$ 167,648		\$ 167,648		\$ 1,478,826	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 561,146	\$ 68,424	\$ 68,424	\$		\$ 334,561	71
72	Current Year Purchases	71,945						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			28,163	28,163			74
75	TOTALS	\$ 633,091	\$ 68,424	\$ 96,587	\$ 28,163		\$ 334,561	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,513,833	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 236,072	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 264,235	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,163	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,813,387	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 24,030 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A	2501	hrs	\$ 57,219	152	\$ 3,483	\$ 993	2,653	\$ 61,695	1
2	Licensed Speech and Language Development Therapist	10A	685	hrs	15,664	51	1,170	23	736	16,857	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	2211	hrs	50,596	193	4,410	786	2,404	55,792	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				58,962		58,962	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S Pharmacy	39,3				18,116		471		18,587	13
14	TOTAL				\$ 123,479	396	\$ 27,179	\$ 61,235	5,793	\$ 211,893	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Manorcare at Normal

0027532

Report Period Beginning: 06/01/00

Ending:

05/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,147	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (64,746))	415,765		3
4	Supply Inventory (priced at)	9,221		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,572		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 429,705	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	101,293		13
14	Buildings, at Historical Cost	2,779,449		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	633,091		16
17	Accumulated Depreciation (book methods)	(1,813,387)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,700,446	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,130,151	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,811	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,693		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,569		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	29,846		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 240,919	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	6,538		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,538	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 247,457	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,882,694	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,130,151	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,855,642	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,855,642	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	561,110	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 561,110	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(534,058)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (534,058)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,882,694	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,718,412	1
2	Discounts and Allowances for all Levels	(781,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,937,412	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	357,587	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 357,587	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,970	12
13	Barber and Beauty Care	15,537	13
14	Non-Patient Meals	152	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	392	16
17	Sale of Drugs	58,069	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,694	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	10,770	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 111,584	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	94	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 94	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,406,677	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	605,082	31
32	Health Care	1,769,521	32
33	General Administration	997,543	33
B. Capital Expense			
34	Ownership	316,196	34
C. Ancillary Expense			
35	Special Cost Centers	157,225	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,845,567	40
41	Income before Income Taxes (line 30 minus line 40)**	561,110	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 561,110	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Manorcare at Normal# 0027532Report Period Beginning: 06/01/00Ending: 05/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,866	3,186	\$ 81,759	\$ 25.66	1
2	Assistant Director of Nursing	837	930	17,032	18.31	2
3	Registered Nurses	6,766	7,522	118,763	15.79	3
4	Licensed Practical Nurses	25,029	27,822	340,106	12.22	4
5	Nurse Aides & Orderlies	73,782	82,017	614,308	7.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,992	5,409	123,756	22.88	7
8	Rehab/Therapy Aides					8
9	Activity Director	7,165	7,975	63,521	7.97	9
10	Activity Assistants					10
11	Social Service Workers	2,158	2,380	25,607	10.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,797	18,693	158,510	8.48	15
16	Dishwashers					16
17	Maintenance Workers	1,896	2,109	33,137	15.71	17
18	Housekeepers	8,342	9,270	71,033	7.66	18
19	Laundry	2,530	2,806	18,681	6.66	19
20	Administrator	1,815	2,080	92,139	44.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,469	9,469	133,133	14.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,599	1,780	15,850	8.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,043	183,448	\$ 1,907,335 *	\$ 10.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	14,975	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	424	3,383	5,11,3	44
45	Social Service Consultant	7	70	5,12,3	45
46	Other(specify) <u>Utilization</u>	10	250	5,10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	441	\$ 18,678		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	938	\$ 14,808	5,10,3	50
51	Licensed Practical Nurses	8,994	109,906	5,10,3	51
52	Nurse Aides	14,879	111,442	5,10,3	52
53	TOTAL (lines 50 - 52)	24,811	\$ 236,156		53

Facility Name & ID Number Manorcare at Normal# 0027532Report Period Beginning: 06/01/00Ending: 05/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Joe Trainor	Administrator	0	\$ 92,139	Workers' Compensation Insurance	\$ 83,444	IDPH License Fee	\$ 1,047
				Unemployment Compensation Insurance	15,413	Advertising: Employee Recruitment	18,122
				FICA Taxes	141,605	Health Care Worker Background Check	
				Employee Health Insurance	118,346	(Indicate # of checks performed <u>45</u>)	904
				Employee Meals		Dues & Subscriptions	1,097
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues	4,077
				401K / SMSP Match	11,244	Advertising	30,700
				Other Employee Benefits	38,212	Public Relations	348
				Disability Payments	509		
				Employee Uniforms	686		
				Payroll Overhead Allocated	1	Less: Public Relations Expense	(348)
				Home Office Allocation	(10,885)	Non-allowable advertising	(21,959)
						Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 92,139	TOTAL (agree to Schedule V, line 22, col.8)	\$ 398,575	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 33,988
(List each licensed administrator separately.)							
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Description	Amount
Management Fees			\$ 280,132			Out-of-State Travel	\$
						In-State Travel	9,064
						Includes travel expense to the Home	
						Office in Toledo, OH for regional	
						meeting	
						Seminar Expense	
						Entertainment Expense	()
						(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 280,132	TOTAL	\$	line 24, col. 8)	\$ 9,064
(Attach a copy of any management service agreement)							
C. Professional Services							
Vendor/Payee	Type		Amount				
	Legal Fees		\$ 4,195				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 4,195				
(If total legal fees exceed \$2500 attach copy of invoices.)							

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$ 4077
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,635 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (152)
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.